



CANNON BUILDING
861 SILVER LAKE BLVD., SUITE 203
DOVER, DELAWARE 19904-2467

STATE OF DELAWARE
DEPARTMENT OF STATE
DIVISION OF PROFESSIONAL REGULATION
EXAMINING BOARD OF PHYSICAL THERAPISTS AND ATHLETIC TRAINERS

TELEPHONE: (302) 744-4500
FAX: (302) 739-2711
WEBSITE: DPR.DELAWARE.GOV

APPLICATION FOR SPECIAL PROJECT/ASSIGNMENT TEMPORARY PHYSICAL THERAPIST LICENSE

INSTRUCTIONS

You may apply for a Special Project/Assignment Temporary Physical Therapist license if you will be practicing **temporarily** in Delaware **solely** in connection with a special project, teaching assignment or medical emergency ([24 Del. C. §2611\(b\)](#)).

- When applying for a Special Project/Assignment Temporary license, you must hold a *current* license in another jurisdiction, but it is not necessary to also apply for a permanent Delaware license by reciprocity.
- You do *not* have to practice under direct supervision while practicing under this kind of temporary license.
- Special Project/Assignment Temporary license are issued for one year.

The following requirements apply *only to* applications for Special Project/Assignment Temporary Licenses:

- ☐ Submit completed, signed and notarized [Application for Special Project/Assignment Temporary License](#) to the Board office.
- ☐ Enclose [temporary license fee](#) by check or money order made payable to "State of Delaware."
- ☐ If you have ever held a license in another jurisdiction, arrange for the Board office to receive verification of licensure from *each* jurisdiction where you have ever held a license, sent *directly* from the jurisdiction to the Board office.

IDENTIFYING AND CONTACT INFORMATION

1. Full Name: _____
Last/Family First Middle
2. Other Names Used: _____
(Include maiden, former married names and alternate spellings.)
3. Date of Birth (month/day/year): _____ Gender: Male ☐ Female ☐
4. Have you been issued a U.S. Social Security Number? Yes ☐ No ☐
 - If yes, enter your SSN: _____
 - If no, you must file a [Request for Exemption from Social Security Number Requirement](#).
5. Mailing Address: _____

City State Zip
6. Phone: _____ Email: _____
daytime evening or cell

NATURE OF SPECIAL PROJECT/ASSIGNMENT

7. When do you expect to be working temporarily in Delaware? From: _____ To: _____
Month/day/year Month/day/year
8. Explain the type of special project, assignment or emergency you will be working on while practicing temporarily in Delaware: _____

LICENSURE HISTORY

9. Have you ever held a license to practice physical therapy in another jurisdiction (state, U.S. territory or District of Columbia)? Yes ☐ No ☐ **If yes, list *each* jurisdiction where you have ever held, a license. If you need more room, enclose a separate sheet.**

JURISDICTION	LICENSE NUMBER	ISSUE DATE	EXPIRATION DATE

Arrange for a verification of licensure to be sent *directly* to the Board office from *each* jurisdiction listed.

DISCLOSURES

10. Have you ever been convicted of or entered a plea of guilty or *nolo contendere* (no contest) to any felony, misdemeanor or any other criminal offense, including any offense for which you have received a pardon, in any jurisdiction? Yes ☐ No ☐ **If yes, submit a certified copy of your criminal history record.**
11. Has your license ever been revoked or suspended or has any other disciplinary action been taken by the authorities of another jurisdiction (including any state, D.C., U.S. territory or other country)? Yes ☐ No ☐ **If yes, enclose a statement explaining fully. Include any relevant documents.**
12. Is any complaint or disciplinary action pending against your license in any other jurisdiction? Yes ☐ No ☐ **If yes, enclose a statement explaining fully. Include any relevant documents.**
13. Has your application for a license or registration ever been refused or denied in any other jurisdiction? Yes ☐ No ☐ **If yes, enclose a statement explaining fully. Include any relevant documents.**

DUTY TO REPORT

14. To obtain a license in Delaware, you must certify that you understand that you have a **mandatory** obligation to file a written report with the Board of Medical Licensure and Discipline within 30 days if you have any reason to believe that a medical practitioner *other than yourself* is (or may be) guilty of unprofessional conduct as defined in 24 Del. C. §1731 OR that he/she is (or may be):
- medically incompetent
 - mentally or physically unable to engage safely in the practice of medicine
 - excessively using or abusing drugs including alcohol.

I certify that I have read and understand the provisions of [24 Del. C. §1730, 24 Del. C. §1731 and 24 Del. C. §1731A](#) and that I understand my *duty to report*. Yes ☐ No ☐

15. To obtain a license in Delaware, you must certify that you understand that you have a **mandatory** obligation to make an immediate oral report to the to the Department of Services for Children, Youth and Their Families if you know of, or you suspect, child abuse or neglect under Chapter 9 of Title 16 and to follow up with any requested written reports.

I certify that I have read and understand [16 Del. C. §903](#) and that I understand my *duty to report*. Yes ☐ No ☐

If Board review is required, the Board office must receive all of these items no later than 4:30 PM ten full working days before the Board's meeting date:

- Completed, signed and notarized application form
- Fee payment
- All required supporting documentation.

Applications that are not complete within six months of filing may be considered abandoned and discarded.

Please note: When your application is complete, please allow 4-8 weeks to receive your license.

AFFIDAVIT

I certify that the information in this application is complete and true. I understand that the intentional inclusion of false or fraudulent information in this application, or the material omission of information which might have a bearing on licensure, may result in the denial of licensure and will be reported to the Attorney General for further action. I understand that the application fee is not refundable.

Signature of Applicant: _____ **Date:** _____

City of _____ County of _____

Sworn to before me and subscribed in my presence this _____ day of _____, 2_____.

Signature of Notary: _____

SEAL

My commission expires: _____

***APPLICATIONS THAT ARE UNSIGNED, NOT NOTARIZED, INCOMPLETE OR NOT ACCOMPANIED BY THE
REQUIRED FEE WILL BE REJECTED.***